California Health Benefit Exchange

Establishment Planning Review

Review Briefing

March 2012

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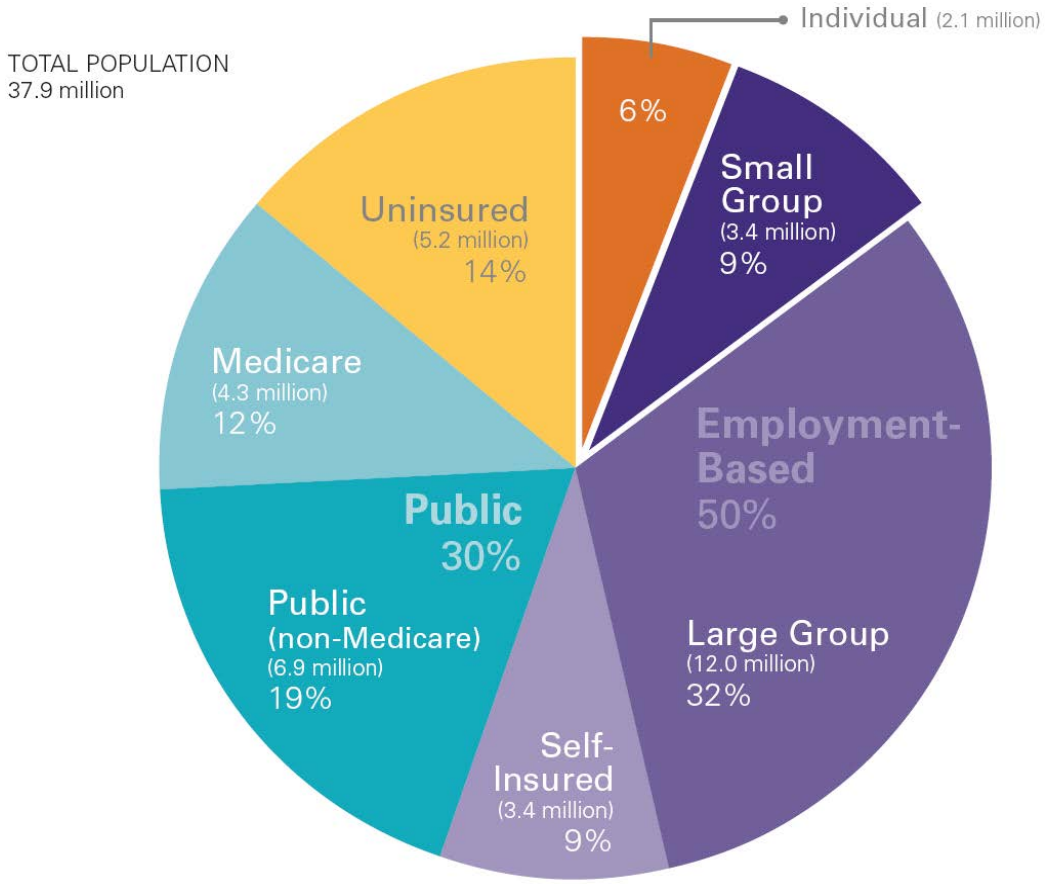
Snapshot: Health Insurance Coverage in California

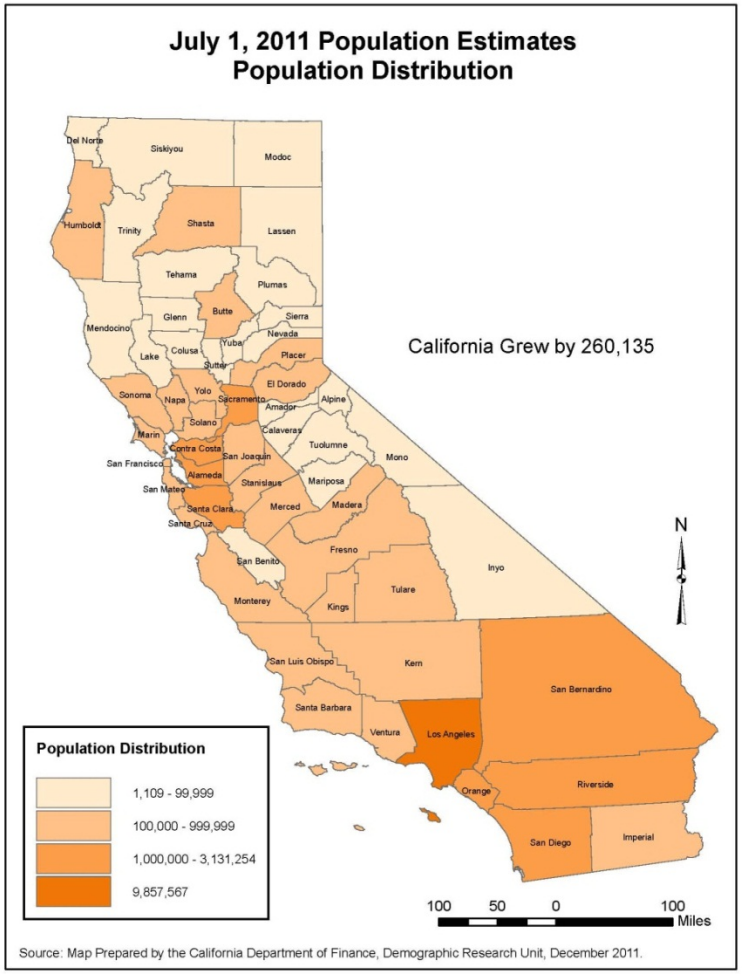
1. Overview



Source: California HealthCare Foundation
SNAPSHOT California's Individual and Small Group Markets on the Eve of Reform, 2011.

Snapshot: California – Many People, Many Markets

1. Overview



Potential Exchange Visions

Price Leader

The Exchange drives lower premiums; it is a cost-focused store and offers the most competitively priced health plans.

Service Center

The Exchange is a consumer destination; it is a consumer-friendly, one-stop shop with broad choices on plan design, accessible information, and strong customer service.

Change Agent

The Exchange is catalyst of finance and delivery reform; establishing incentives to encourage innovation and improvement in the cost, quality, and efficiency in health care delivery.

Public Partner

The Exchange is closely aligned with Medi-Cal and Healthy Families partnering to adopt an array of policies that align to improve the health status and health care outcomes of low-income, high-need individuals.

Source: "California's Health Benefit Exchange: The Future Envisioned," California Healthcare Foundation, August 2011.

California Exchange Vision & Mission

Vision

To improve the health of all Californians by assuring their access to affordable, high quality care

Mission

Increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value

California Exchange Values

Consumer-focused

At the center of the Exchange's efforts are the people it serves, including patients and their families, and small business owners and their employees. The Exchange will offer a consumer-friendly experience that is accessible to all Californians, recognizing the diverse cultural, language, economic, educational and health status needs of those we serve.

Affordability

The Exchange will provider affordable health insurance while assuring quality and access.

Catalyst

The Exchange will be a catalyst for change in California's health care system, using its market role to stimulate new strategies for providing high-quality, affordable health care, promoting prevention and wellness, and reducing health disparities.

Integrity

The Exchange will earn the public's trust through its commitment to accountability, responsiveness, transparency, speed, agility, reliability, and cooperation.

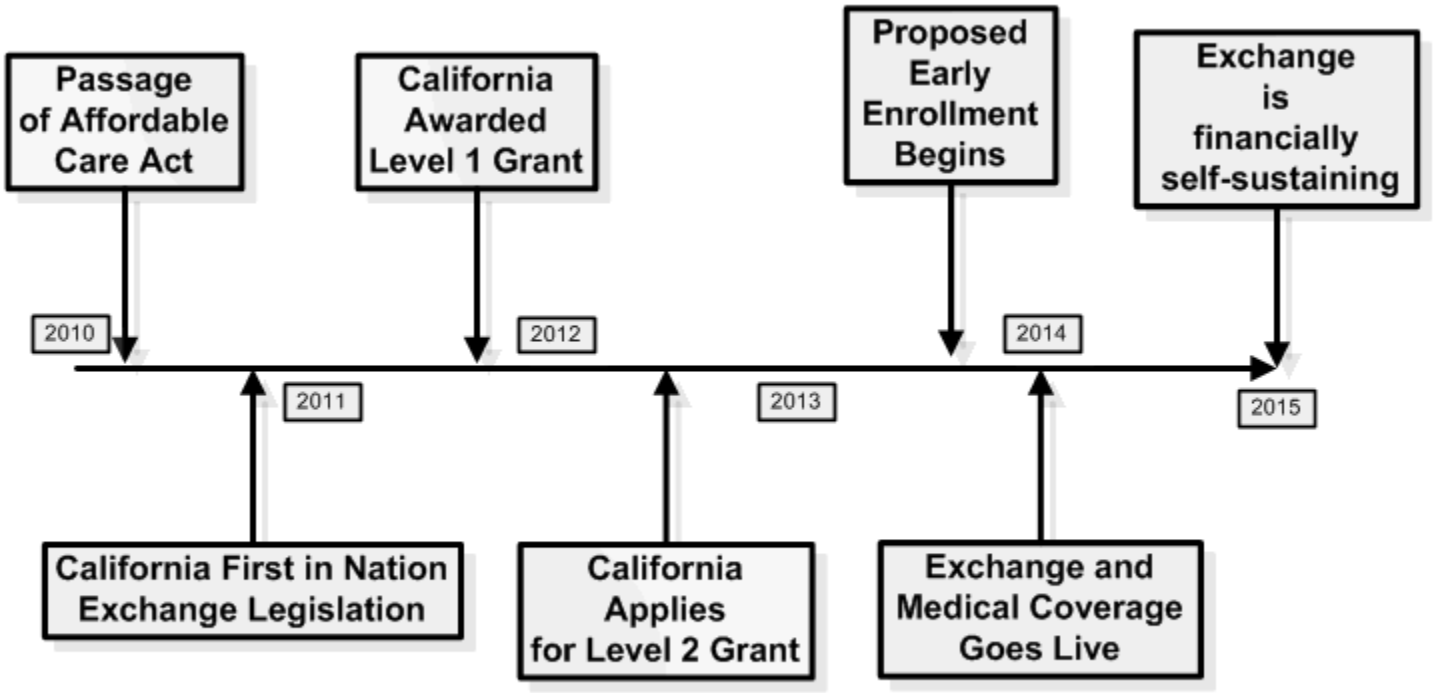
Partnership

The Exchange welcomes partnerships, and its efforts will be guided by working with consumers, providers, health plans, employers and other purchasers, government partners, and other stakeholders.

Results

The impact of the Exchange will be measured by its contributions to expanding coverage and access, improving health care quality, promoting better health and health equity, and lowering costs for all Californians.

Timeline for California Health Benefit Exchange



California Exchange Established by Legislation in 2010

SB 900 (Alquist)

- Establishes the Exchange Board
- Establishes basic administrative procedures

AB 1602 (Pérez)

- Requirements on Exchange per Section 1311 of federal law
- Requirements on Exchange per state law
- Permissive authorities of Exchange
- Other provisions including General Fund protections

Board Responsibilities & Members

1. Overview

The Exchange Board has a responsibility and duty to:

- Meet the requirements of the title, the federal act, and all applicable state and federal laws and regulations
- Serve the public interest of the individuals and small businesses seeking health care coverage through the Exchange
- Ensure the operational well-being and fiscal solvency of the Exchange

Board members:

Diana Dooley – Board Chair and Secretary of the California Health and Human Services Agency, which provides a range of health care services, social services, mental health services, alcohol and drug treatment services, income assistance and public health services to Californians

Kim Belshé – Senior Policy Advisor of the Public Policy Institute of California, former Secretary of California Health and Human Services Agency, and former Director of the California Department of Health Services

Paul Fearer – Senior Executive Vice President and Director of Human Resources of UnionBanCal Corporation and its primary subsidiary, Union Bank N.A., Board Chair of Pacific Business Group on Health, and former board chair of Pacific Health Advantage

Robert Ross, M.D. – President and Chief Executive Officer of The California Endowment, previous director of the San Diego County Health and Human Services Agency from 1993 to 2000, and previous Commissioner of Public Health for the City of Philadelphia from 1990 to 1993

Susan Kennedy – Nationally-recognized policy consultant, former Deputy Chief of Staff and Cabinet Secretary to Governor Gray Davis, former Chief of Staff to Governor Arnold Schwarzenegger, former Communications Director for U.S. Senator Dianne Feinstein, and former Executive Director of the California Democratic Party

Board Process

1. Overview

- Board meets monthly; to date Board has met 15 times
- Board meetings are governed by the Bagley-Keene Open Meeting Act:
  - All meetings with a quorum of Board members are publicly noticed with an agenda at least 10 days before the meeting
  - Public is allowed to provide comment after each agenda item
- Board meetings are webcast, with provision for phone comments; participants from across the state and observers from across the nation
- Meetings held in Sacramento, with some meetings across the state (2012 meetings scheduled for Fresno, Los Angeles and San Francisco)
- The Exchange's website is continually updated to reflect Board actions and ensure that the public has the most current information about the Exchange's activities

Pending State Legislation

- Medi-Cal Eligibility/MAGI
  (SB 677-Hernandez & AB 42-Monning)
- Risk Adjustment, Reinsurance, Risk Corridor
  (SB 728-Hernandez)
- Individual Market
  (SB 961 & AB1461)
- Small Group Market
  (AB 1083-Monning)
- Essential Health Benefit
  (AB 1453 and SB 951)
- Enrollment –Outreach
  (AB 792 – Bonilla & AB 714- Atkins)
- Basic Health Plan
  (SB 703)

Policy Decision Framework

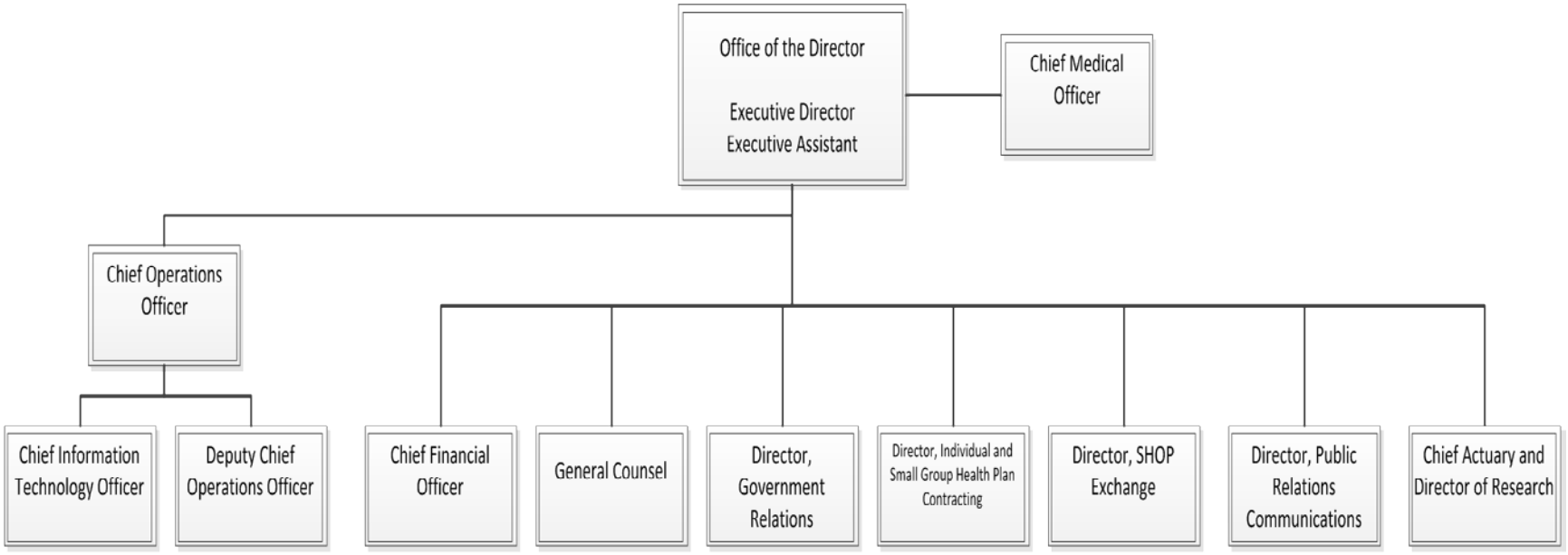
1. Legal scope
   - Regulatory requirements
   - Prohibited approaches
   - Allowable alternatives
2. “Just the facts”
   - Current California activities
   - California and national relevant data
3. Stakeholder perspectives
4. Options and recommendations
5. Detailed budget and timeline for Level II grant

2. Administrative Activities

Organization Overview
Staffing Plan
Solicitations & Contracts
Budget
Cost Allocation Summary
Financial Sustainability

Organization Overview

2. Administrative Activities



Staffing Plan

The Exchange staffing plan is under development. Factors influencing required staff resources include:

- ***Enrollment projections*** will affect the level of staff resources needed to operate the Exchange and provide customer service support
- ***Workload –*** Decisions concerning the functions of the Exchange will have bearing on future workload and associated staffing projections
- ***Timing –*** Staffing considerations will need to be based on the rollout schedule of Exchange functions and programs

Solicitations & Contracts

2. Administrative Activities

Outstanding	Description	Value	Date
Project Management/Technical Services for CalHEERS	Provide project management, business analysis, testing and technical architecture review	Not to exceed $9,400,000	5/2/2012-5/1/14
Independent Verification and Validation for CalHEERS	Provide IV&V services for the CalHEERS project	Not to exceed $1,600,000	5/1/12 – 7/1/14

Awarded	Description	Value	Date
Business and Operations	Business and operational planning	$454,045	10/10/11-1/31/14
Health Plan Management	Develop standards for QHP participation	Not to exceed $700,000	3/6/12-11/1/12
Outreach and Education	Design and develop a comprehensive Navigator, Agent and Broker Program	Not to exceed $900,000	3/8/12 – 10/31/13
SHOP	Identify strategies and approaches to maximize the effectiveness of the SHOP program	Not to exceed $400,000	2/29/12- 6/1/12

Budget

2. Administrative Activities

Budget Item	Level 1 Grant Budget
Salaries	$5,697,506
Fringe (Benefits)	$2,335,977
Travel	$230,000
Supplies	$382,500
Equipment	$255,000
Consultant / Contractual	$29,247,900
Other	$1,642,500
TOTAL DIRECT COSTS	**$39,791,383**

Cost Allocation Plan Summary

2. Administrative Activities

The cost allocation plan encompasses one-time funding requested for D&I. Following the completion of procurement activities, the proposed cost allocation methodology will be reviewed and revised as appropriate.

At the time that an accepted vendor contract has been negotiated and an Advance Planning Document Update (APDU) is prepared, the cost allocation methodology will be adjusted.

Requirements	Req. Count	Exchange	Exchange/ Medicaid	Medicaid	CHIP
Individual Business	251	134	202		4
SHOP	292	290	0	2	0
Total	**643**	**424**		**11**	
Allocation of Shared Requirements		101		101	
Total		**525**		**114**	**4**
% Allocated by Program		***81.6%***		***17.7%***	***0.6%***

Financial Sustainability–Context

2. Administrative Activities

- Exchange must be self sustaining in 2015
- Operating revenue to come from assessments paid by health plans and insurers
- No federal funds will be awarded after January 1, 2015
- Exchange has no state General Fund expenditure authority
- Statute established the California Health Trust Fund
- Board to maintain a prudent reserve

Financial Sustainability–Revenue Modeling

2. Administrative Activities

Summary

- Develop options for revenue models to ensure the financial sustainability of the California Health Benefit Exchange

Options for consideration

- Analysis/impact of varying levels of assessments on health plans
- Implications of fee assessments on plans inside and outside the Exchange

Current approach

- Contracting for expertise to develop options for sustainability
- Analysis of when fee should be implemented to ensure appropriate “cash flow” for the Exchange
- Analysis of mechanism to collect and monitor revenue dollars

Financial Sustainability–Fee Structure

2. Administrative Activities

Summary

The Exchange must establish its own source of funding to become self-sufficient beginning January 2015. The Exchange has authority under state law to impose fees on Qualified Health Plans. In addition, an interim funding source may be needed to pay for Navigators who enroll eligible individuals into the Exchange in 2013 and 2014 – prior to the collection of ongoing Exchange revenues. There may also be a need for identifying a funding source to pay the non-federal share for assisters who enroll Medi-Cal eligible individuals.

Exchange fee options and issues include:

- Plan-based fees on products
- Enrollment-based fees on a flat, per capita assessment or as percentage of premium
- Enrollment-based fees with potentially variable levels for any combination of QHP-lives in the Exchange; QHP-lives inside and outside the Exchange; carriers inside/outside the Exchange; all carriers in the individual market

Exchange fee options and issues (cont.)

- All fee options require legal analysis to determine if they are consistent with the requirements of Proposition 26, which was added by the voters to the State Constitution in November 2010 (Prop 26 established a strict standard for defining fees, which can be imposed with a majority vote of the Legislature, vs. taxes, which require a two thirds vote)

Current approach:

- The Exchange is engaging health plans and other constituents in consultation
- The Exchange has contracted with the Wakely Group to provide additional expertise and analysis to develop recommendations on fee structure and design issues.

3. Plan Management

Benefit Plan Design: Cost Sharing Standardization
Plan Selection & Certification Standards
Supplemental Benefits
Provider Directories
Plan Financial Management

Benefit Plan Design: Cost Sharing Standardization

3. Plan Management

Summary

California will need to determine the Essential Health Benefits within the parameters set federally. We currently anticipate that the selection of a benchmark plan for California will be done by legislation. The Exchange will need to determine, within the federal standards, the cost-sharing and benefit designs within the Essential Health Benefits.

Options for consideration

- For each "metal level," set standard cost-sharing requirements for QHPs to maximize consumer comparison and simplify plan selection
- Set standard cost-sharing requirements for the majority (or most) of what plans offer through the Exchange, but allow some cost-sharing to vary from the standard approach

Options for consideration (cont.)

- Permit plans seeking certification as a QHP to design their own cost-sharing features within each "metal level"
- Primarily offer QHPs with standardized cost-sharing features, but permit a small number to utilize customized cost-sharing approaches

Current approach

- Evaluate the cost-sharing features of the individual and small group markets' most popular plans being sold today
- Determine how much variability exists in cost-sharing in today's most popular plans
- Consider consumer and provider feedback regarding variation vs. standardization of cost-sharing features of QHPs

Plan Selection & Certification Standards

3. Plan Management

Summary

The Exchange needs to certify and select Qualified Health Plans in time for their promotion to individuals and small groups by Fall of 2013 – in advance of open enrollment commencing in October. Exchange standards for certification should be robust and evidence-based but flexible in their application to provide the right choice and price points to consumers. The Exchange board is considering how this process will reflect its authority in its enacting legislation to be an "active purchaser." The Exchange is seeking to balance the need to promote affordable products – which may entail use of narrow networks or medical management practices – with the interest in many provider and consumer advocates in focusing on assuring access to a broad range of providers.

Approach

- Certification standards will build on existing " minimum state standards" and not "reinvent the wheel."
- The Exchange's decisions about what plans to offer should be informed by current market knowledge of the most popular and successful plans sold by industry leaders in California.

Options for consideration (cont.)

- The Exchange should adopt standards that measure quality and provider network accessibility, including language assistance capacity, which build on existing regulatory, purchaser or accreditation measures.
- The Exchange will consider certification standards that allow for incremental improvements in driving delivery system reform over time, such as including assessment of plans' participation in patient-centered medical homes, pay for performance provider arrangements.

Next steps

- Evaluate the current individual and small group market offerings to make the Exchange an attractive place to buy health insurance while balancing with the goal of driving reform.
- Identify measurable quality and provider network adequacy standards to ensure high performing health plans are available through the Exchange.
- Continue to coordinate with regulators to avoid duplication of effort and to incorporate their efforts into the certification process.

Supplemental Benefits

3. Plan Management

Summary

In order to achieve a greater degree of “one-stop shopping” in the Exchange, the Exchange is considering offering supplemental dental and/ or vision benefits for individuals and small groups.

Options for consideration

- Consider the scope and nature of the offering of dental and/or vision benefit offerings, considering initially offering fewer options later to allow the Exchange to focus on getting the health insurance plan offerings right in 2014
- Offer only the simplest and most basic affordable dental and/ or vision plans in 2014 reserving the option to upgrade in subsequent years based on 2014 experience

Current approach

- Evaluate whether the simplicity of offering dental and/or vision benefits through the Exchange website will attract and retain buyers in 2014
- Identify the most popular and market-successful dental and vision offerings available
- Meet with California’s dental and vision plan market leaders to better understand their current offerings and how they might tailor new offerings for sale through the Exchange at competitive price points which add value to these services

Provider Directories

3. Plan Management

Summary

In order to facilitate consumer choice, the Exchange should require provider directories that most accurately reflect network providers available to consumers through the QHPs in a user-friendly way.

Options for consideration

- Create and operate a “consolidated” provider network directory that would allow a shopper to search for a provider and quickly ascertain which QHPs include any given provider
- In lieu of a consolidated provider directory on the Exchange website, or in combination with a consolidated provider listing, offer a link from the Exchange’s website to the website of a QHP issuer to access robust provider search functionality

Next steps

- Evaluate provider directories offered by health insurance industry leaders in California and identify best practices
- Conduct a preliminary evaluation of the IT requirements to create, maintain and update a consolidated provider directory on the Exchange website once QHPs are selected.
- Determine the level of detail about open/closed practice status, office hours, languages spoken and the like that should be contained in an Exchange consolidated provider directory or a QHP issuer’s website.
- Evaluate how to ensure that electronic provider directories are operational for shoppers with limited English proficiency.

Basic Health Program

3. Plan Management

Summary

- The Basic Health Program (BHP) would establish a program for individuals between 138 and 200% FPL. By allowing reduced cost sharing, BHP could provide a more affordable product for some consumers, but it could also reduce the pool to the Exchange with implications for Exchange viability and cost of coverage for those remaining in the Exchange.
- The State Legislature is now considering legislation to enact the BHP. Passage of the measure will be informed by forthcoming federal regulations.

Considerations and assumptions

- Whether or not there is a BHP has significant implications for design and structure of the Exchange's financial sustainability plan in the Level II grant application
- Implementation of the BHP would have significant implications for the implementation of the CalHEERS contract and all service functions

Current approach

- The Exchange is doing planning based on current legal context, which does not include a BHP, but is doing modeling and planning in the event BHP legislation is enacted.

Plan Management Discussion Topic

- Implications of multi-state plans

4. SHOP Activities

SHOP Scope & Approach

SHOP Scope & Approach – Outreach

SHOP Scope & Approach

Summary

The Exchange must develop and design a successful and appealing Small Business Health Options Program (SHOP) where employers can purchase health insurance and provide coverage to their employees.

Options for consideration

- Eligibility and enrollment processes and operational functions.
- Offered product portfolio (e.g., types of products, benefit designs, supplemental benefits such as dental and vision coverage, etc.)
- Requirements and standards for plan participation
- Options to support small employers' benefits administrations (e.g., FSA, HRA or Section 125 accounts, etc.)
- Employer and employee standards (e.g., choice in health plan and benefit designs, structure of employer/employee contributions, etc.).
- Distribution channels for marketing and sales of small group products.
- Role and payment structure models for broker and agent involvement.

SHOP Scope & Approach – Outreach

Next steps

- Engage contractor to develop recommendations for SHOP implementation, including:
  - Estimate potential enrollment in the SHOP (e.g., small employer market status and market opportunities).
  - Evaluate and inventory current small group market offerings so that the SHOP can become an appealable, attractive, and competitive place for employers to purchase health insurance.
  - Evaluate implications of contracting out (all or in part) SHOP administrative and operational functions.
  - Evaluate marketing strategies that need to be employed in order to maximize employer and employee participation.

5. Eligibility & Enrollment Activities

Eligibility & Enrollment Pathways

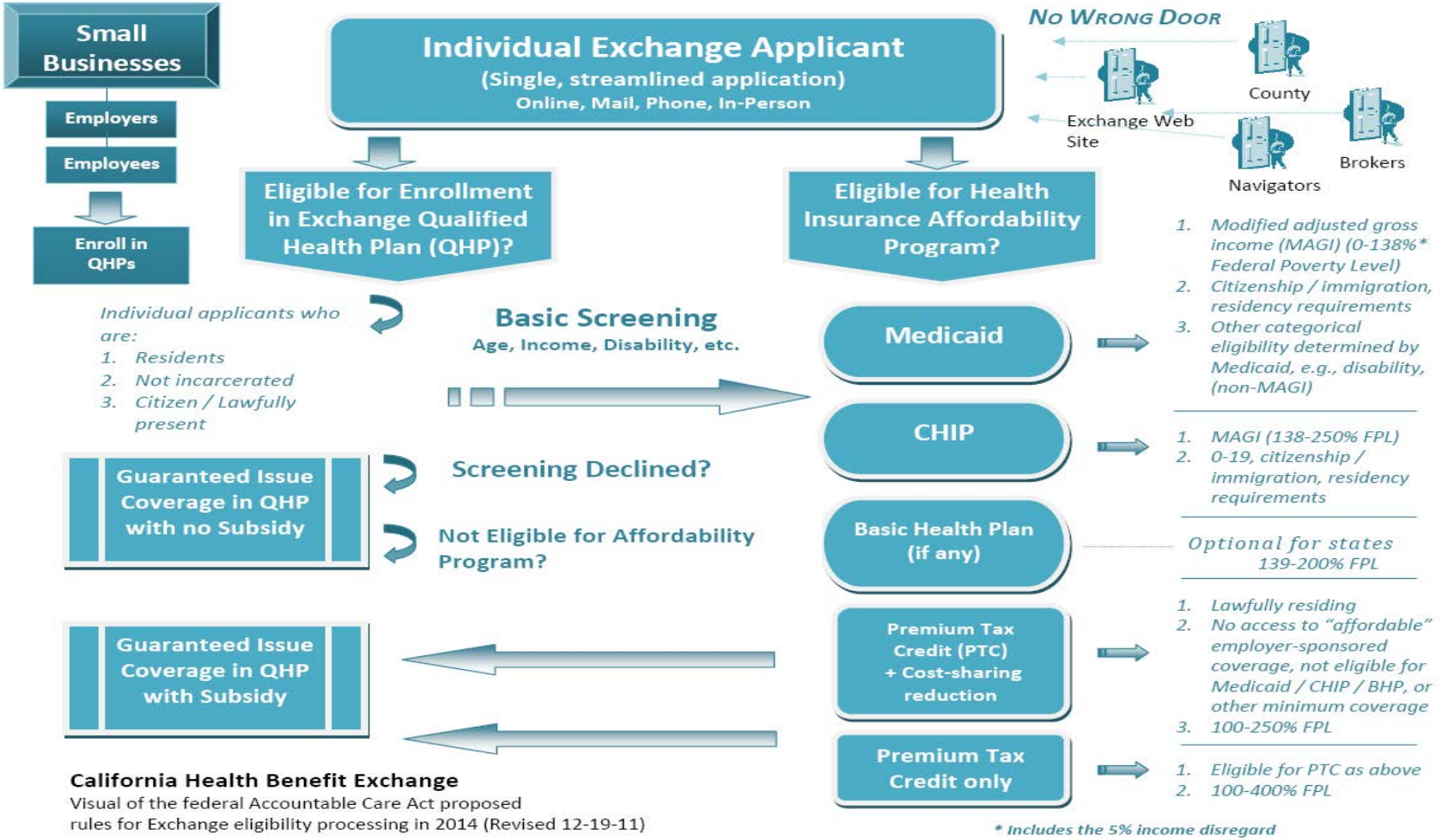
Program Design Goals

Service Center Scope & Structure

Berkeley/UCLA Enrollment Projections

Eligibility & Enrollment Issues

Eligibility & Enrollment Pathways



California Health Benefit Exchange
Visual of the federal Accountable Care Act proposed rules for Exchange eligibility processing in 2014 (Revised 12-19-11)

Program Design Goals

5. Eligibility & Enrollment Activities

1. “No Wrong Door” service system that provides consistent consumer experiences for all entry points
2. Culturally and linguistically appropriate oral and written communications which also ensure access for persons with disabilities
3. Seamless and timely transition between health programs
4. Minimize burden of establishing and maintaining eligibility
5. Assures security and privacy of consumer information
6. Enables real-time, accurate eligibility determinations
7. Enables transparency and accountability
8. Enables consumers to have no gaps in coverage
9. Enables consumers to make informed choices

Enrollment Projections

5. Eligibility & Enrollment Activities (CalSIM)

California Simulation of Insurance Markets (CalSIM)

Health Insurance Coverage in California under the Affordable Care Act

UC Berkeley Labor Center, UCLA Center for Health Policy Research

Presentation to the California Health Benefit Exchange Board

March 22, 2012

CalSIM: Factors Influencing Behavioral Response

5. Eligibility & Enrollment Activities (CalSIM)

Firms	Individuals
Employer response determined by change in relative cost of job-based coverage and the cost of coverage in the exchange, taking into account:	Factors Affecting Individual Coverage Decisions:
	Starting source of coverage (without ACA)
Tax Benefit of job-based coverage	Change in cost to purchase insurance, including subsidies
Employer penalties	Individual Responsibility penalty
Value of Exchange subsidies available to employees	Household income
Differences in plan value	Health status as indicated by the presence of chronic conditions
Employee response	English proficiency
Age and health status of workforce	Age as a predictor of premium

CalSIM General Modeling Approach

5. Eligibility & Enrollment Activities (CalSIM)

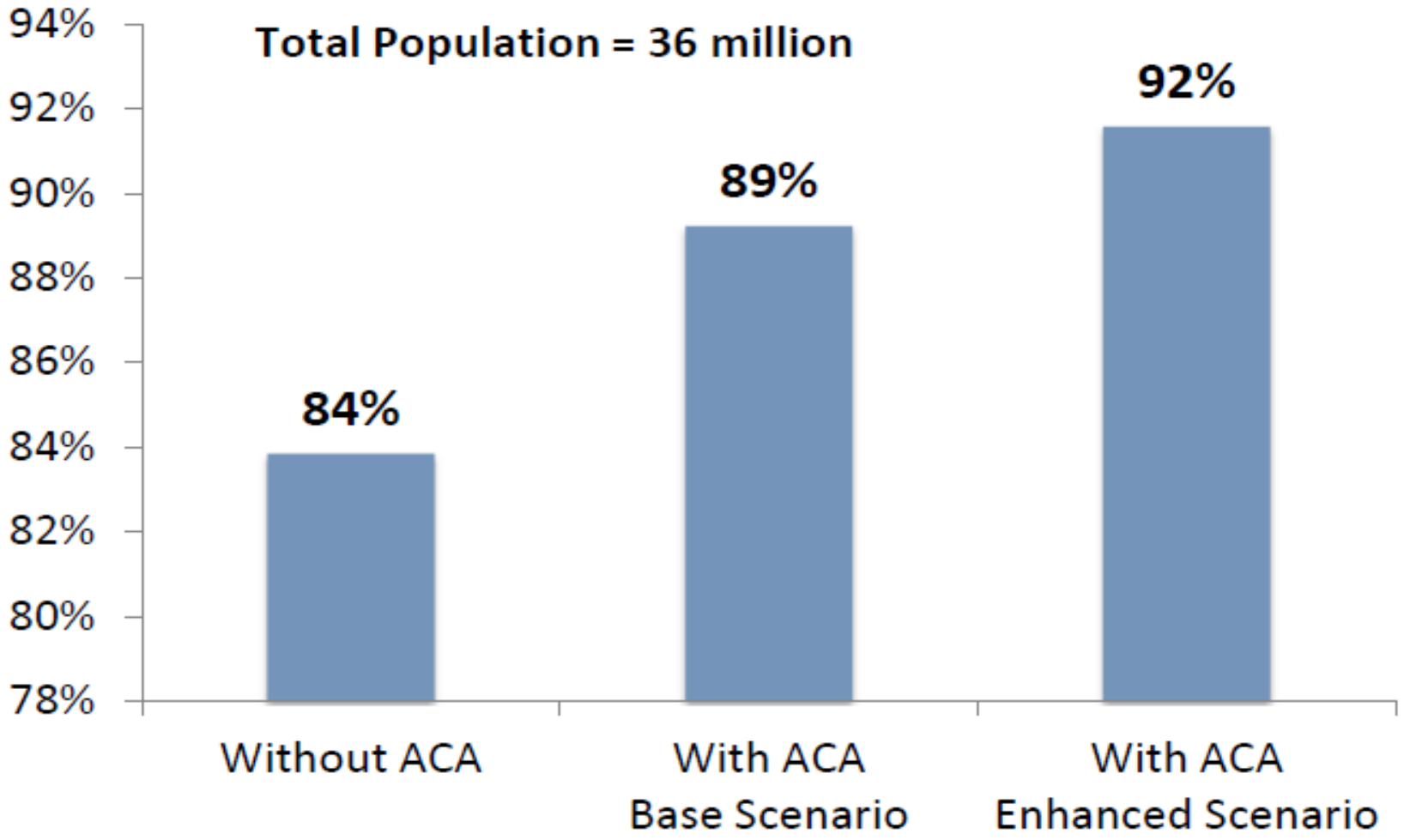
Base Scenario

- Propensities for individuals to take up coverage are based on the best available data from the health economics literature
- Medi-Cal take-up for newly eligible is projected to match the current take-up rate in the state for the uninsured (61%)
- Medi-Cal take-up for previously eligible, but uninsured, will be 10%
- Limited English Proficient (LEP) individuals will be less likely to enroll

Enhanced Scenario

- Factors taken into account:
  - Simplification of eligibility determination
  - Strong outreach and education
  - No-wrong door
  - Cultural sensitivity and language appropriate outreach and enrollment
  - Maximum use of pre-enrollment strategies
- Assumes 75% take-up for Medi-Cal for new eligibles and 40% for previously eligible but uninsured
- Assumes 70% take-up of the uninsured into the subsidized exchange

Exhibit 1. Percentage of Non-Elderly Population with Insurance in California, 2019



Note: Based on U.S. Census Bureau, Population Division, Interim State Population Projections, 2005.

Source: UC Berkeley-UCLA CalSIM model, Version 1.6

Exhibit 2a. Changes Due to Policy in Types of Coverage for Californians under 65 years old (in millions) 2019, *Base Scenario*

Type of Coverage	Without ACA 2019	Adding due to ACA	Leaving due to ACA	Net policy change	After ACA 2019
Employer Sponsored	19.78	0.35	-1.06	-0.71	19.07
Medi-Cal	5.90	1.26	-	1.26	7.15
Healthy Families	0.80	0.14	-0.33	-0.19	0.62
Other Public	1.26	-	-	-	1.26
Exchange with Subsidies	-	1.75	-	1.75	1.75
Individual Market/Exchange without Subsidies[1]	2.29	0.90	-1.08	-0.19	2.10
Uninsured, eligible for coverage	4.73	0.28	-2.22	-1.94	2.79
Uninsured, undocumented	1.06	0.07	0.06	0.01	1.07

[1]Previous micro-simulation modeling literature estimates a range of 46-73% of this group will enroll through the Exchange.

Source: UC Berkeley-UCLA CalSIM model, Version 1.6

Exhibit 2b. Changes Due to Policy in Types of Coverage for Californians under 65 years old (in millions) 2019, *Enhanced Scenario*

Type of Coverage	Without ACA 2019	Adding due to ACA	Leaving due to ACA	Net policy change	After ACA 2019
Employer Sponsored	19.78	0.35	-1.06	-0.71	19.07
Medi-Cal	5.90	1.62	-	1.62	7.51
Healthy Families	0.80	0.20	-0.33	-0.13	0.67
Other Public	1.26	-	-	-	1.26
Exchange with Subsidies	-	2.12	-	2.12	2.12
Individual Market/Exchange without Subsidies[1]	2.29	0.97	-1.11	-0.13	2.15
Uninsured, eligible for coverage	4.73	0.26	-3.00	-2.74	1.99
Uninsured, undocumented	1.06	0.7	-0.10	-0.03	1.03

[1]Previous micro-simulation modeling literature estimates a range of 46-73% of this group will enroll through the Exchange.

Exhibit 3a. Coverage by Source for Californians under 65 years old 2014-2019 (in millions), *Base Scenario*

Type of Coverage	Without ACA 2014	With ACA 2014	With ACA 2016	With ACA 2019
Employer Sponsored	19.15	19.15	19.10	19.07
Medi-Cal	5.71	6.64	6.89	7.15
Healthy Families	0.78	0.58	0.60	0.62
Other Public	1.22	1.22	1.24	1.26
Exchange with Subsidies	-	0.87	1.43	1.75
Individual Market/Exchange without Subsidies	2.21	1.71	1.92	2.10
Uninsured, eligible for coverage	4.58	3.50	2.95	2.79
Uninsured, undocumented	1.03	1.00	1.00	1.07

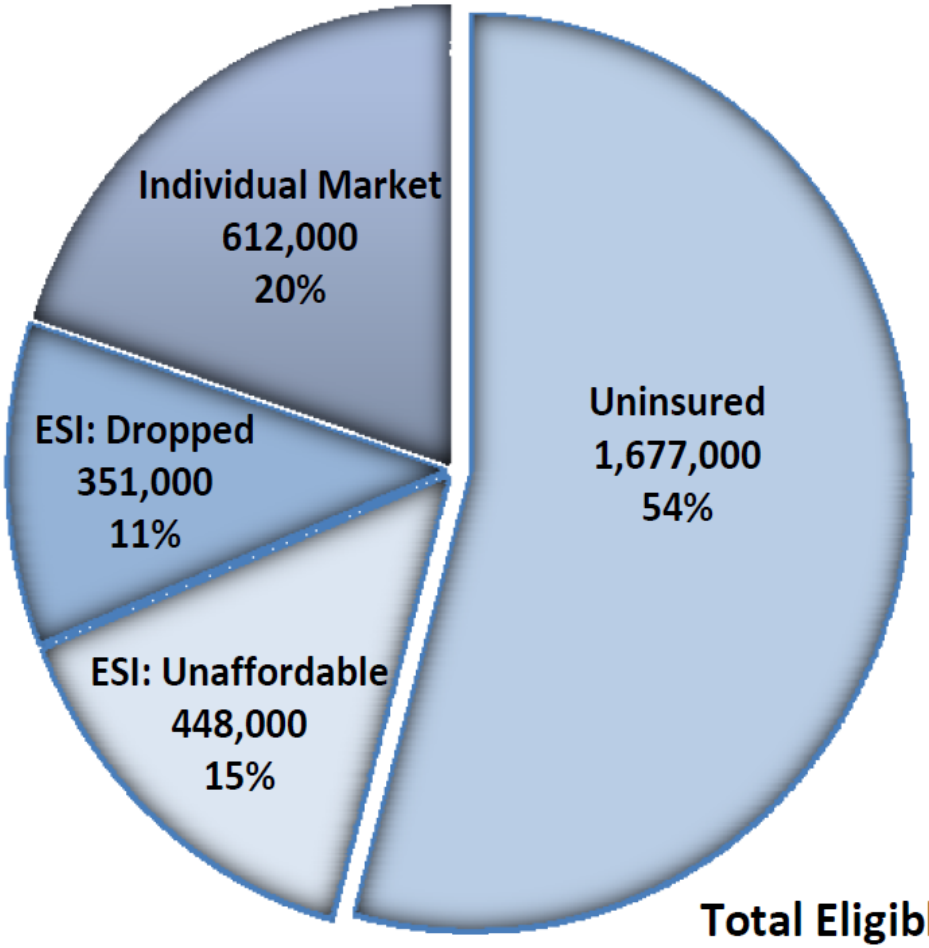
Source: UC Berkeley-UCLA CalSIM model, Version 1.6

Exhibit 3b. Coverage by Source for Californians under 65 years old 2014-2019 (in millions), *Enhanced Scenario*

Type of Coverage	Without ACA 2014	With ACA 2014	With ACA 2016	With ACA 2019
Employer Sponsored	19.15	19.14	19.08	19.07
Medi-Cal	5.71	7.14	7.36	7.51
Healthy Families	0.78	0.63	0.66	0.67
Other Public	1.22	1.22	1.24	1.26
Exchange with Subsidies	-	1.15	1.99	2.12
Individual Market/Exchange without Subsidies	2.21	1.70	2.03	2.15
Uninsured, eligible for coverage	4.58	2.71	1.77	1.99
Uninsured, undocumented	1.03	0.98	1.00	1.03

Source: UC Berkeley-UCLA CalSIM model, Version 1.6

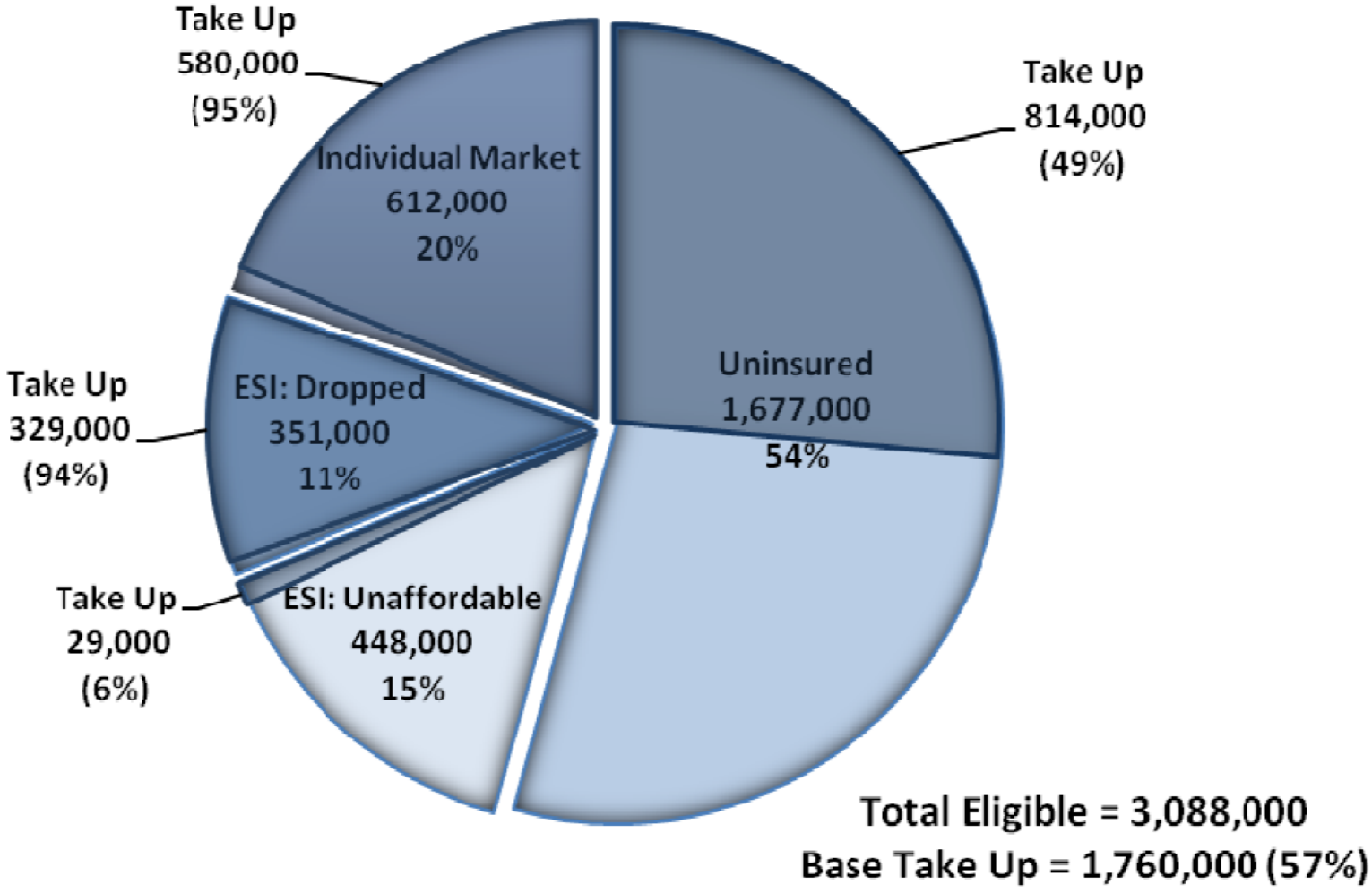
Exhibit 4a. Exchange Subsidy Eligible by Source of Insurance without the ACA, 2019



Total Eligible = 3,088,000

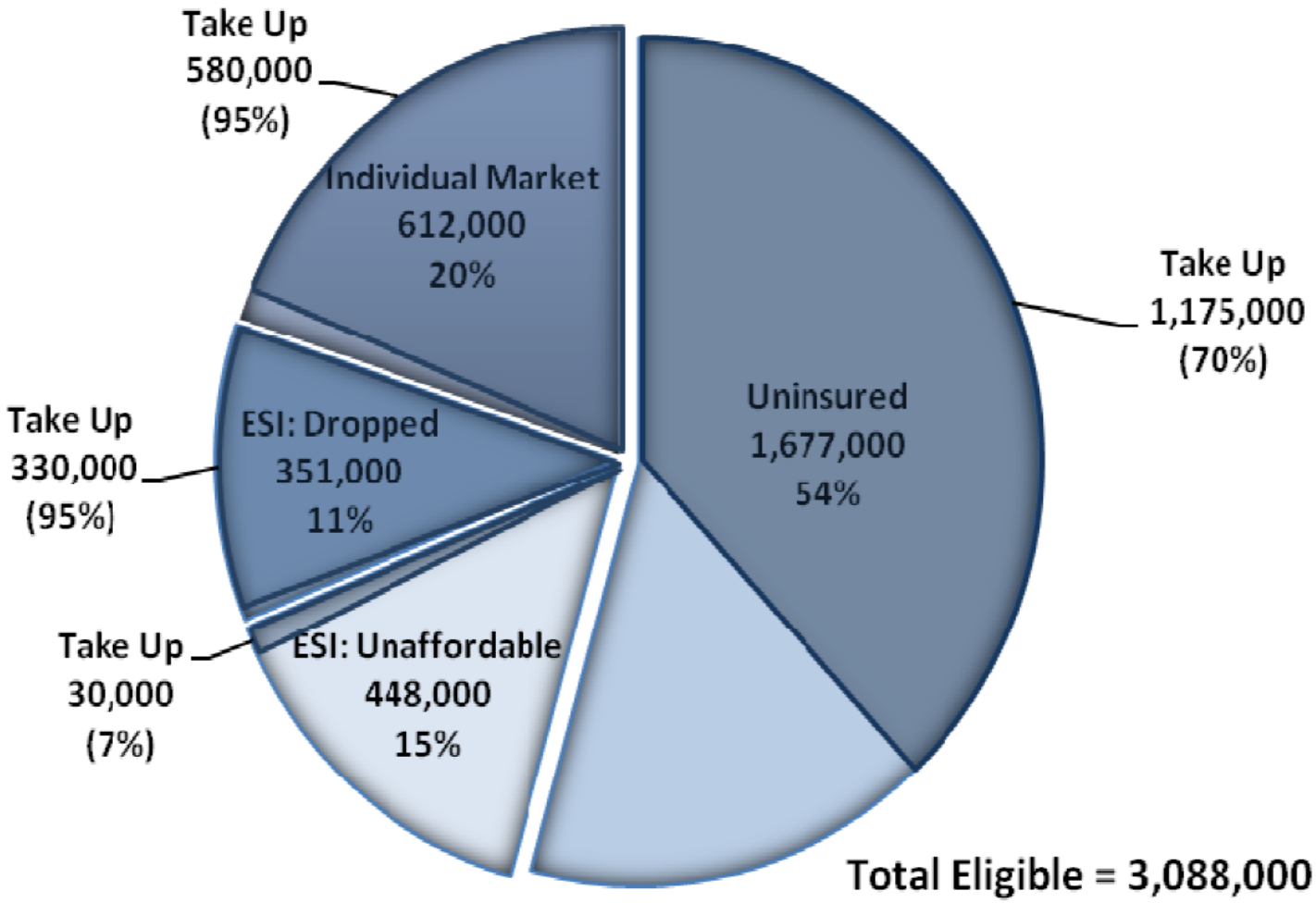
Source: UC Berkeley-UCLA CalSIM model, Version 1.6

Exhibit 4b. Share of Exchange Subsidy Eligible Taking Up Under Base Scenario, 2019



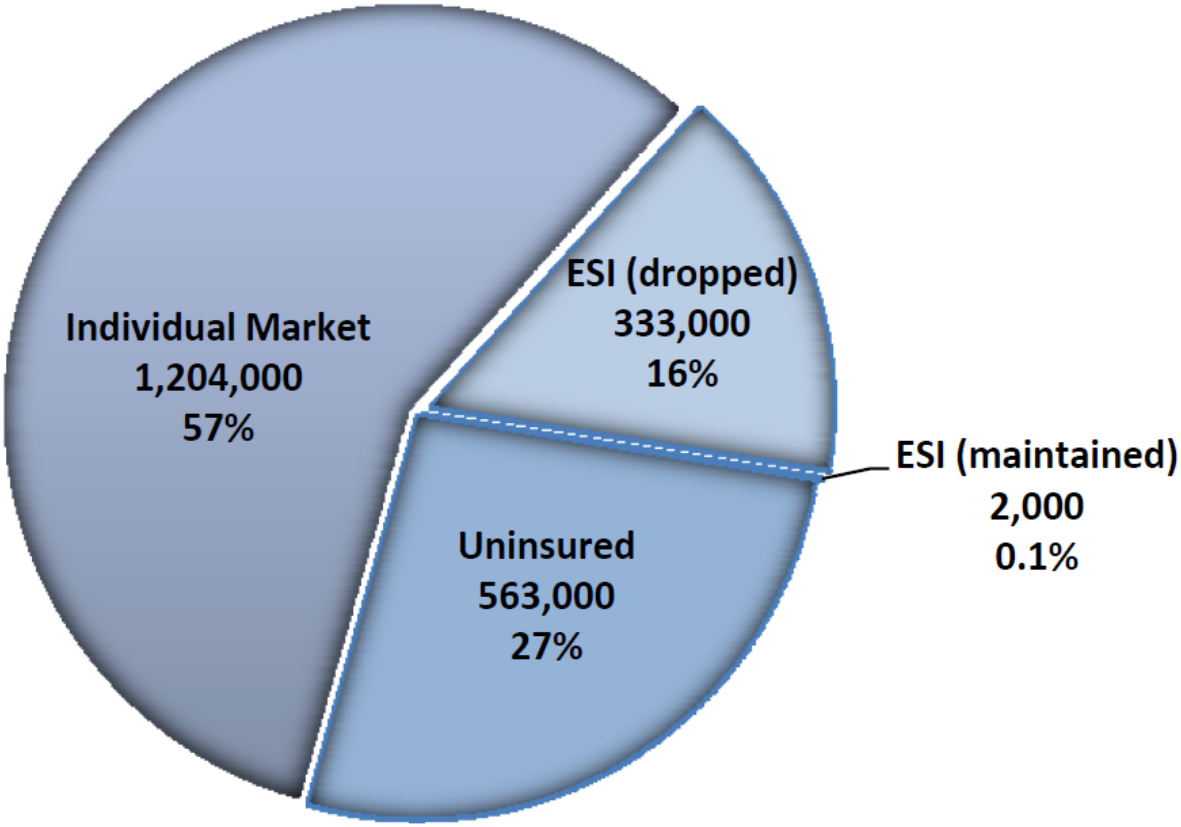
Source: UC Berkeley-UCLA CalSIM model, Version 1.6

Exhibit 4c. Share of Exchange Subsidy Eligible Taking Up Under Enhanced Scenario, 2019



Source: UC Berkeley-UCLA CalSIM model, Version 1.6

Exhibit 9. Source of Previous Insurance Coverage for Those Who Take Up Coverage without Subsidies in the Exchange or Individual Market, *Base Scenario*, 2019



Total Enrolled = 2,099,000

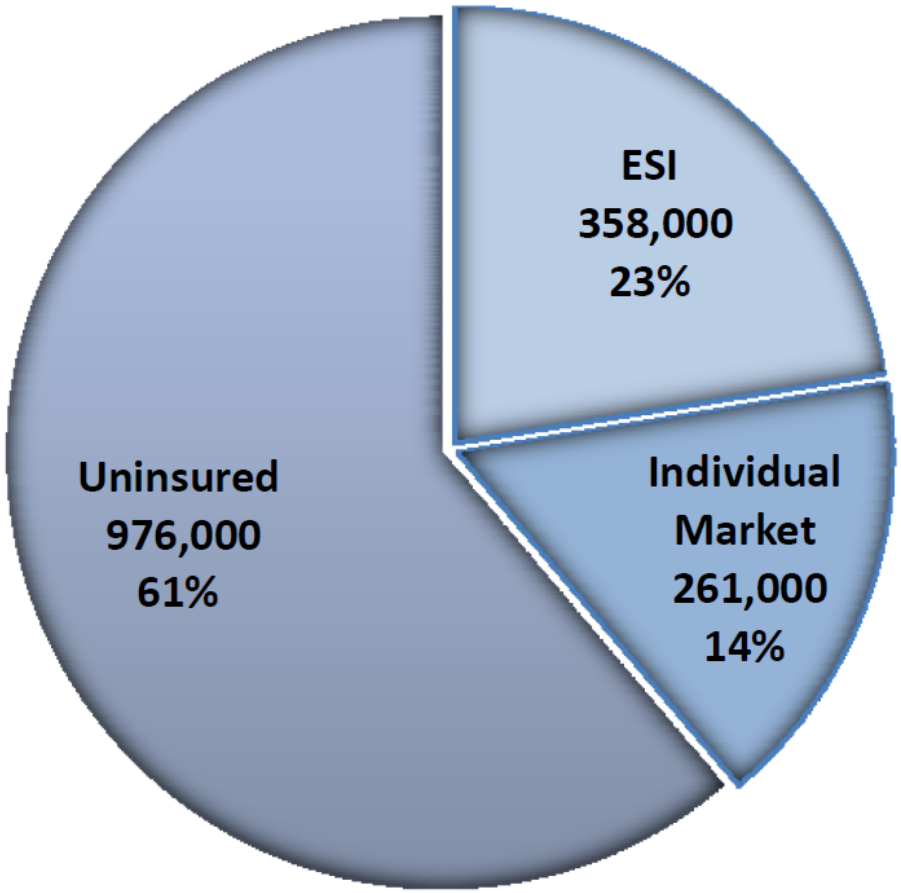
Source: UC Berkeley-UCLA CalSIM model, Version 1.6

Exhibit 11. Distribution of Chronic Conditions Among the Non-Elderly in the Individual Market, 2019

	Individual Market Without the ACA		Exchange and Individual Market with the ACA, *Base Scenario*		Exchange and Individual Market with the ACA, *Enhanced Scenario*	
No chronic conditions	1,666,000	73%	2,784,000	72%	3,167,000	74%
One or more chronic conditions	619,000	27%	1,067,000	28%	1,098,000	26%
Total	**2,285,000**		**3,851,000**		**4,265,000**	

Source: UC Berkeley-UCLA CalSIM model, Version 1.6

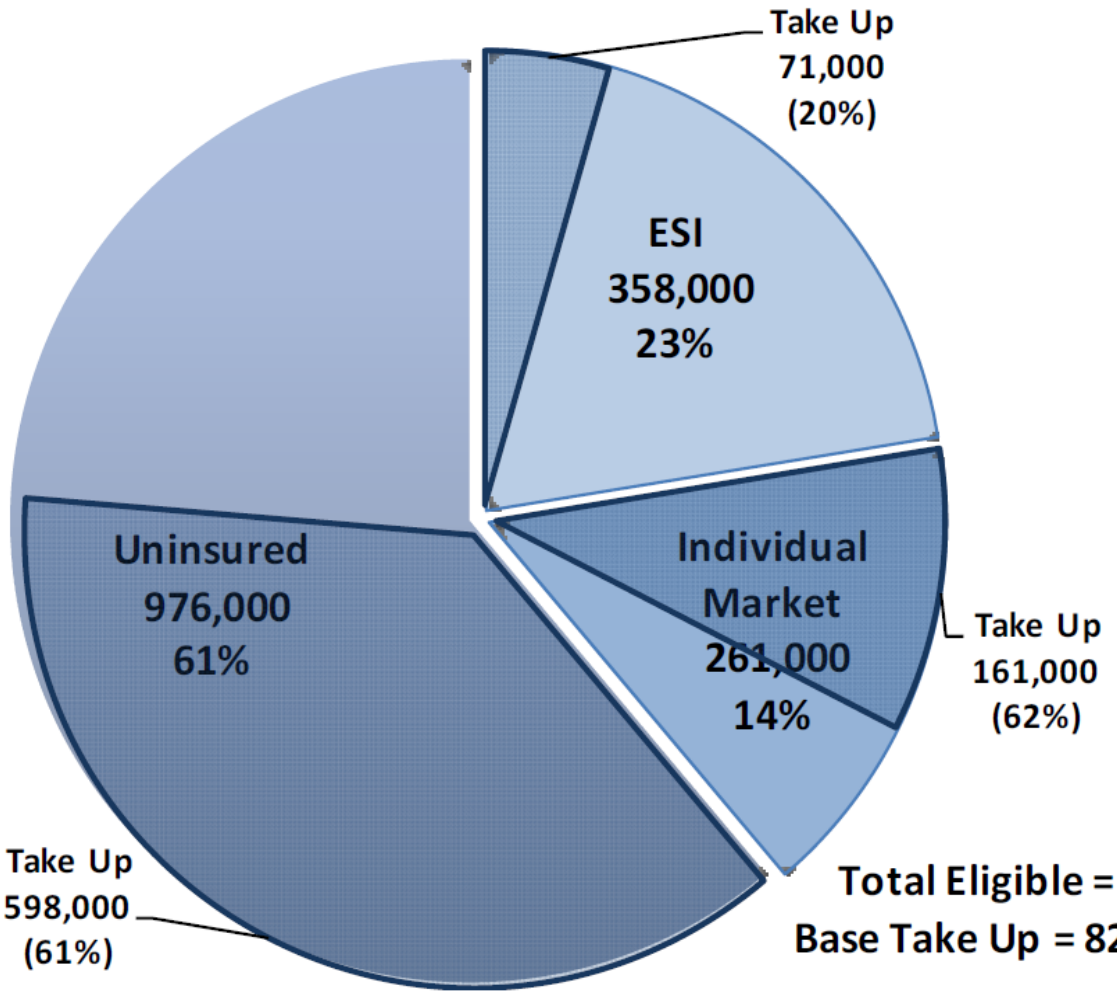
Exhibit 12. Newly Eligible for Medi-Cal by Source of Insurance without the ACA, 2019



Total Eligible = 1,595,000

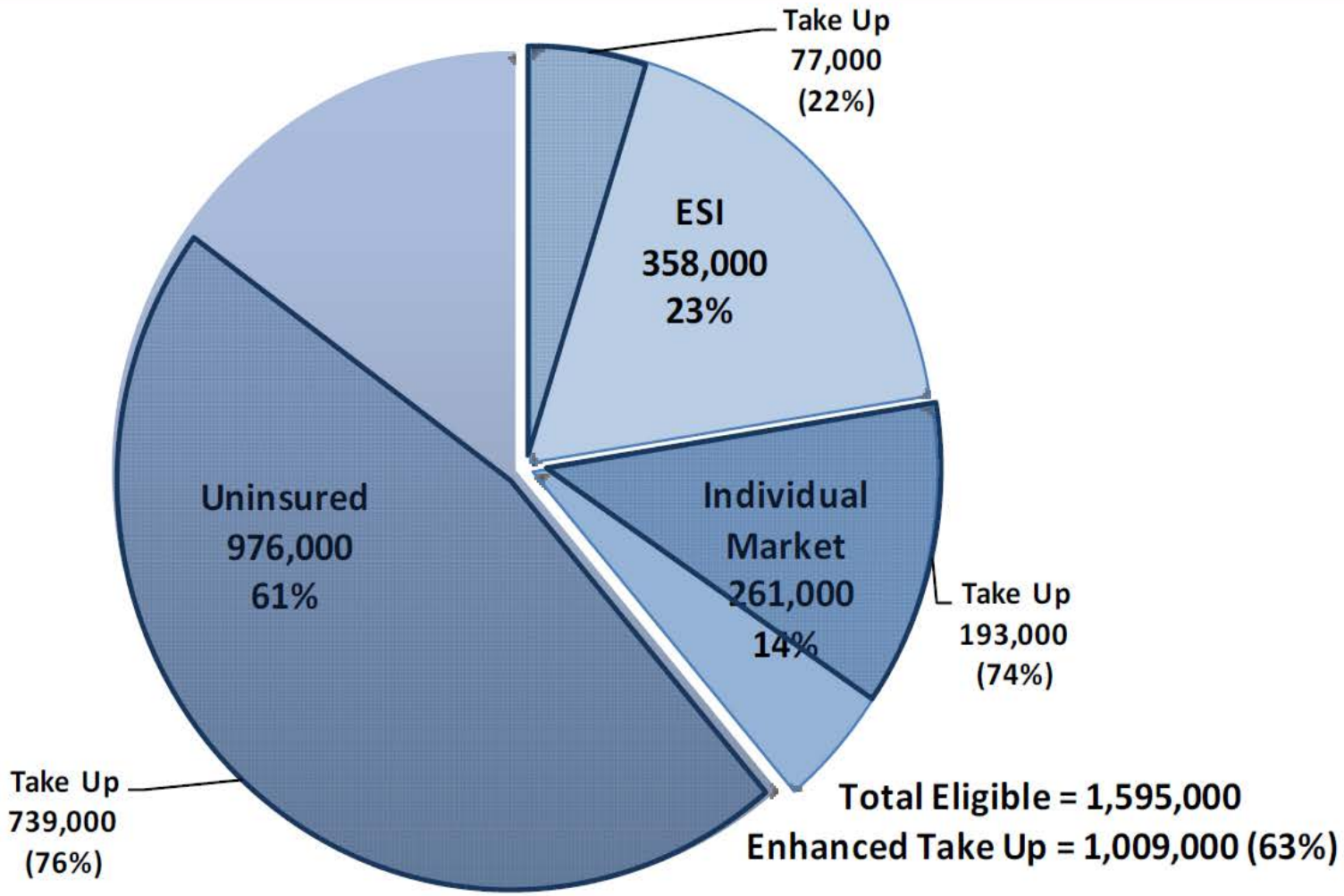
Source: UC Berkeley-UCLA CalSIM model, Version 1.6

Exhibit 13. Share of Newly Eligible for Medi-Cal Taking Up Under Base Scenario, 2019



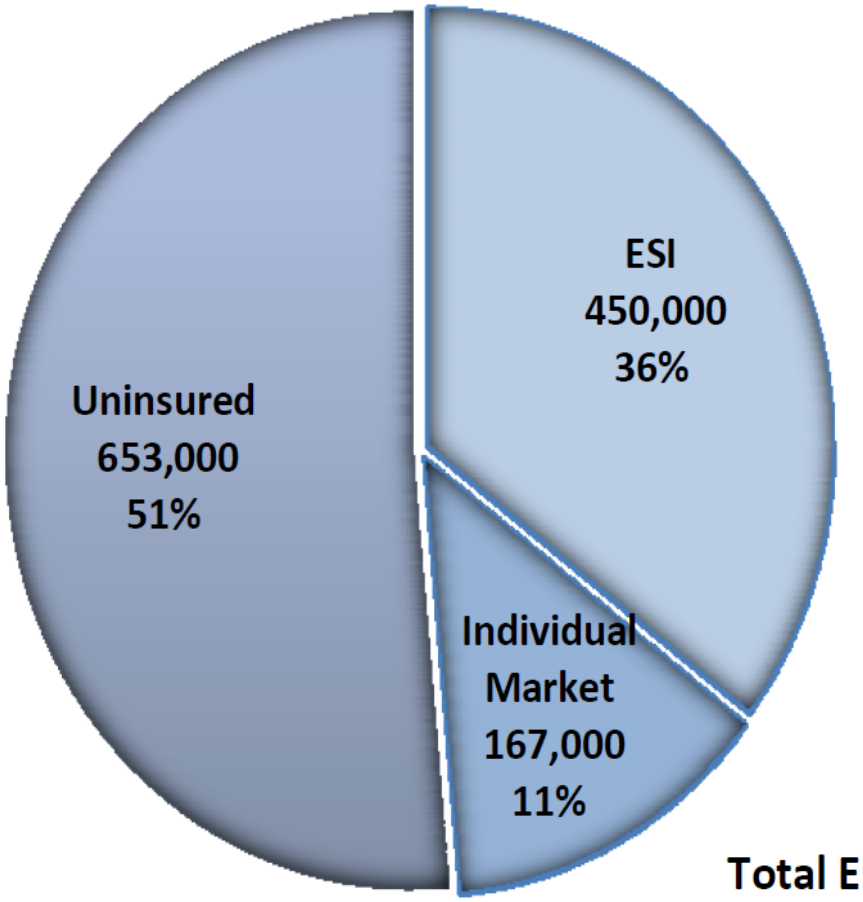
Source: UC Berkeley-UCLA CalSIM model, Version 1.6

Exhibit 14. Share of Newly Eligible for Medi-Cal Taking Up Under Enhanced Scenario, 2019



Source: UC Berkeley-UCLA CalSIM model, Version 1.6

Exhibit 17. Non-Elderly Previously Eligible for Medi-Cal or Healthy Families but Not Enrolled by Source of Insurance without ACA, 2019

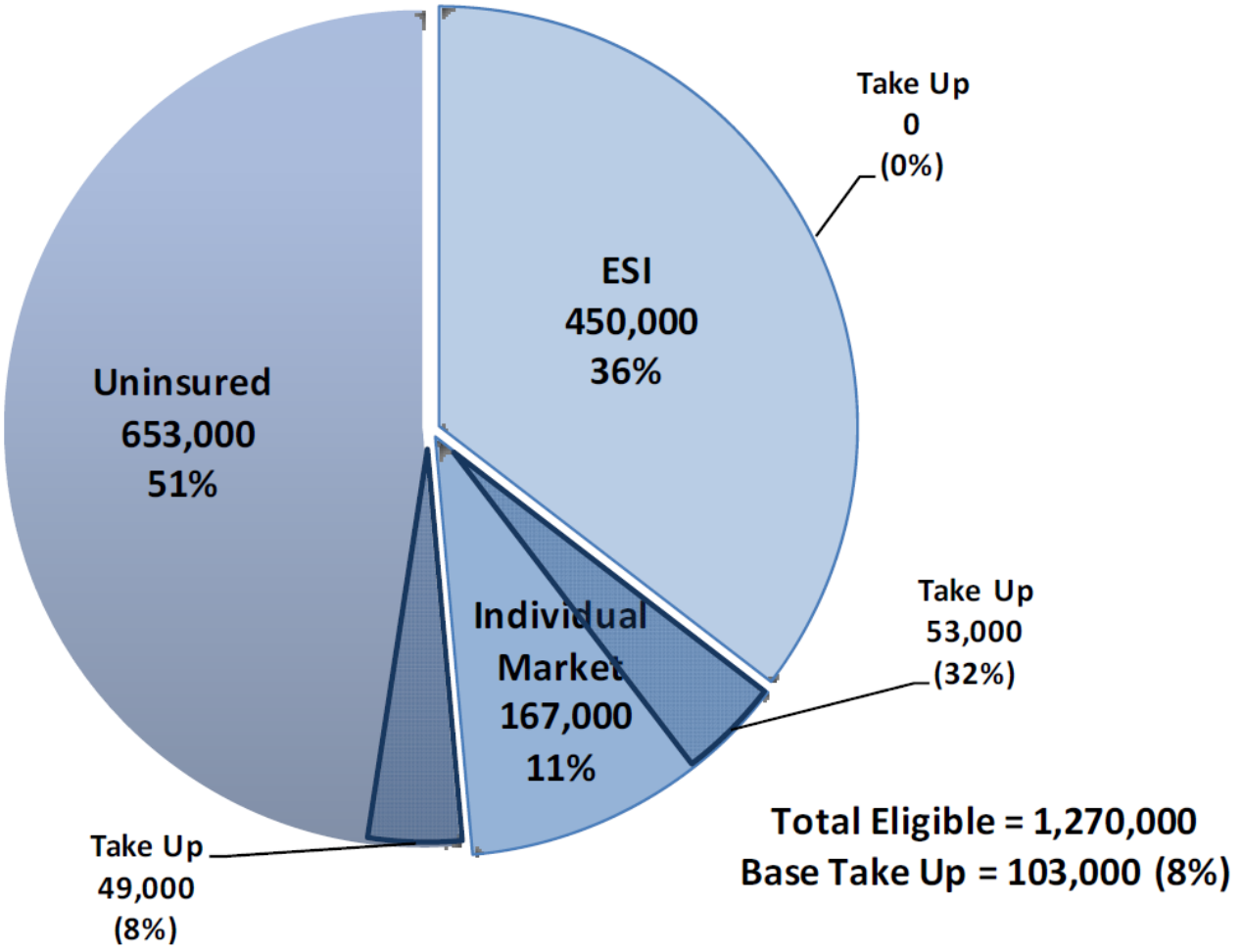


Total Eligible = 1,270,000

Note: Only includes incomes from 0-200% of FPL (age <1) and 0-138% of FPL for age 1 or over

Source: UC Berkeley-UCLA CalSIM model, Version 1.6

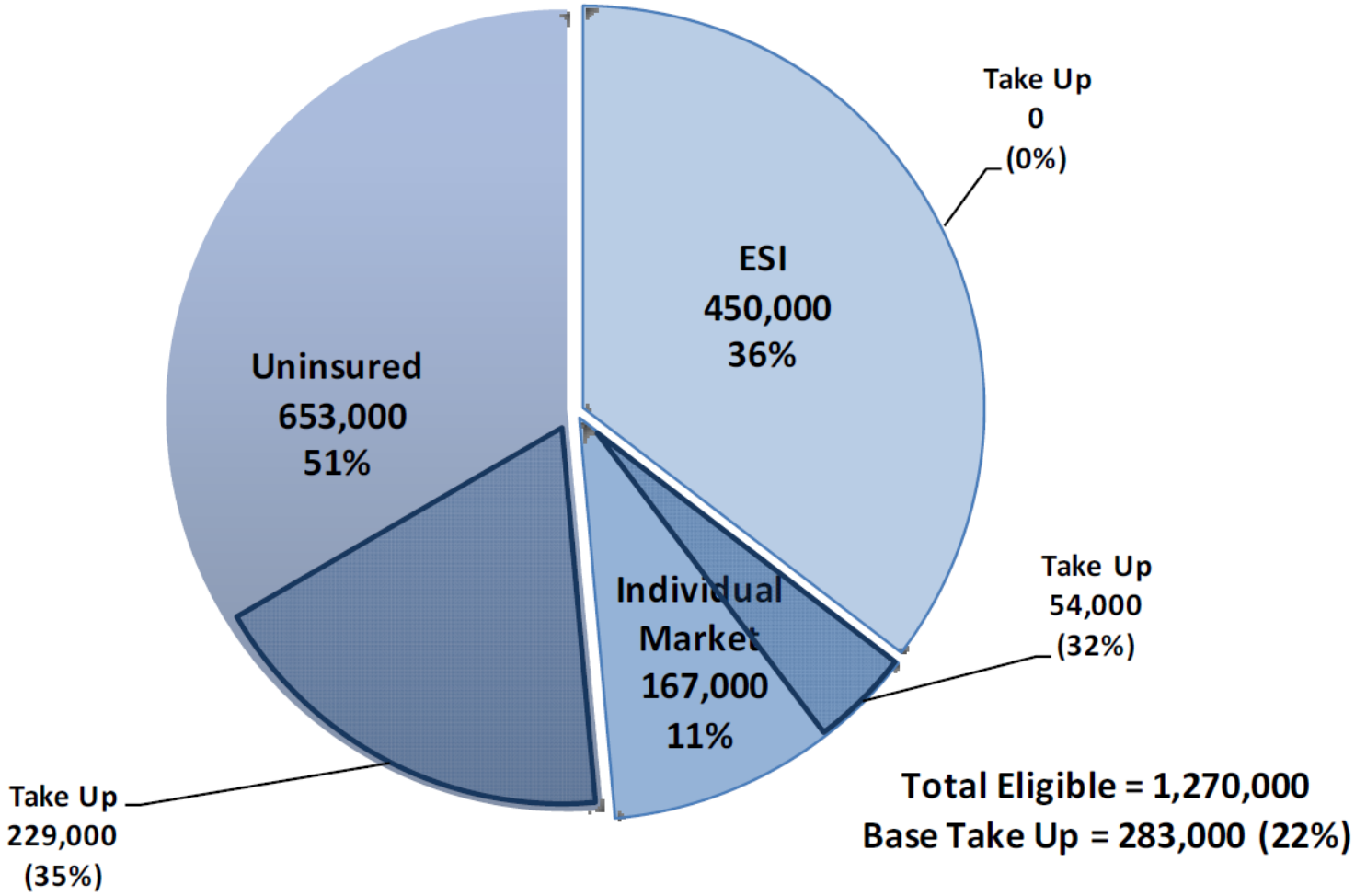
Exhibit 18. Share of Non-Elderly Previously Eligible for Medi-Cal or Healthy Families but Not Enrolled Taking Up *Medi-Cal* under Base Scenario, 2019



Note: Only includes incomes from 0-200% of FPL (age <1) and 0-138% of FPL for age 1 or over; does not include additional Healthy Families take-up.

Source: UC Berkeley-UCLA CalSIM model, Version 1.6

Exhibit 19. Share of Non-Elderly Previously Eligible for Medi-Cal or Healthy Families but Not Enrolled Taking Up *Medi-Cal* under Enhanced Scenario, 2019



Note: Only includes incomes from 0-200% of FPL (age <1) and 0-138% of FPL for age 1 or over; does not include additional Healthy Families take-up.

Source: UC Berkeley-UCLA CalSIM model, Version 1.6

Exhibit 22. Characteristics of the Remaining Uninsured with ACA, 2019

	Base		Enhanced	
	Individuals	Percent of Remaining Uninsured	Individuals	Percent of Remaining Uninsured
Undocumented	1,073,000	28%	1,033,000	34%
Eligible for Medi-Cal or Healthy Families	1,130,000	29%	743,000	25%
Eligible for Exchange Subsidies	782,000	20%	429,000	14%
Eligible for Exchange without Subsidies	883,000	23%	820,000	27%
400% FPL or less	226,000	6%	211,000	7%
Greater than 400% FPL	657,000	17%	609,000	20%
Total	**3,862,000**		**3,025,000**	
Remaining uninsured exempt from individual penalty	54%		56%	

Source: UC Berkeley-UCLA CalSIM model, Version 1.6

Eligibility & Enrollment Issues

Summary

Eligibility determination and enrollment for insurance affordability programs including MAGI Medi-Cal, Healthy Families, and the Exchange will be centralized in the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS)

Issues for consideration

- ***Federal regulations.*** Reviewing recently-released regulations to identify requirements and options for eligibility and enrollment processes
- ***Detailed design.*** Working to identify and address eligibility and enrollment policy and process decisions to inform detailed design of CalHEERS
- ***Staffing plan.*** Developing staffing plan for eligibility and enrollment policy development and operations

Current approach

- ***Program sponsor collaboration.*** The Exchange is working closely with DHCS and MRMIB (collectively "program sponsors") to develop CalHEERS.
- ***Preparing for detailed design.*** Program sponsors are reviewing the recently-released eligibility regulations to inform eligibility and enrollment policy and process development. Policies and processes will be finalized during detailed design of CalHEERS.

Service Center Scope & Structure

3. Eligibility & Enrollment Activities

Summary

The Exchange is in the process of reviewing options for handling all mail and phone service related functions. Service center activities relate to the CalHEERS eligibility, enrollment and retention system as well as business process management for Exchange, Medicaid and Healthy Families eligible individuals.

Key issues and options

- The Exchange needs to assure high levels of customer service, while planning for great uncertainty and potential volatility in calls, interest and enrollment.
- Many families will have members eligible for multiple programs and many individuals will have relatively fluid eligibility over time, requiring service capacity.

Key issues and options (cont.)

The Exchange needs to coordinate service issues with the Department of Health Care Services and assure that existing capacity – in particular county workers and systems – are used effectively.

Current approach

- The Exchange is reviewing service options and the relation of those options to existing capacity and the demands for surge capacity during the launch of the expanded coverage.
- The Exchange is considering options that would maintain some Exchange-specific service functions on an ongoing basis (e.g., the SHOP; management of the Navigator/Assisters) from those that could overtime be handled “virtually” by county-based staff in multiple locations.

Eligibility and Enrollment Discussion Topic

- Interim final regulation impacts on federal eligibility and enrollment artifacts

6. Risk Adjustment & Reinsurance Activities

California's Approach to Risk Adjustment & Reinsurance

California's Approach to Risk Adjustment & Reinsurance

6. Risk Adjustment & Reinsurance Activities

Summary

In order to produce affordable premiums for buyers through the Exchange in 2014, the Qualified Health Plans certified by the Exchange must rely on strong and successful premium stabilization achieved through the temporary reinsurance and permanent risk adjustment programs operated by the applicable State entity.

Key issues and options

- Decisions about which "applicable State entity" will operate the reinsurance or risk adjustment programs in California will likely be made by the State legislature in 2012.
- The Exchange has already begun collaborating with both of California's health insurance regulators, the Department of Managed Health Care and the California Department of Insurance, to be sure that all premium stabilization programs are as effective as possible

Key issues and options (cont.)

- The Exchange has already begun collaborating with both of California's health insurance regulators, the Department of Managed Health Care and the California Department of Insurance, to be sure that all premium stabilization programs are as effective as possible

Current approach

- The Exchange is collaborating with state regulators to seek industry input regarding set-up and operation decisions for the reinsurance and risk adjustment programs in California
- In collaboration with the state's regulators, seek consumer and other stakeholder input regarding set-up and operation of the reinsurance and risk adjustment programs in California
- Ensure that the Exchange's needs are fully considered by decisions made by other state entities

7. Marketing, Outreach, & Enrollment

Stakeholder Input Process

Stakeholder Perspectives

Ogilvy Presentation

Navigator Strategy

Marketing, Outreach, Enrollment & Retention Stakeholder Input Process

Channels for input

- Written comments
- Small group sessions
- Stakeholder comment letters and reports
- Exchange Board meetings

Next steps for incorporating input

- Development work being conducted by Ogilvy and RHA
- Exchange Board program and policy planning

Marketing, Outreach, Enrollment and Retention Stakeholder Input Process

Small group sessions

- Small group sessions convened by the Exchange, Department of Health Care Services, Managed Risk Medical Insurance Board and Office of the Patient Advocate
- 17 sessions convened around the state
- Separate sessions convened for consumer advocates, providers, county representatives and brokers
- Participants serve or represent over 25 California urban and rural counties

Written comments

- Written comments submitted by over 30 individuals and organizations

Stakeholder Perspectives on Success

Successful coverage expansion

- Focus on core competencies needed for successful launch in 2014
- Recognize Exchange should expand focus over time to delivery system reform, health improvement and linkages to other programs

Enrollment success

- Estimates ranged from 20% of eligible individuals enrolled by the end of 2014 to 100% by the end of 2019
- Affordability of products, effective outreach and simplicity of enrollment systems will impact success

Stakeholder Perspectives on Marketing, Promotion and Outreach

Strategies for reaching target populations

- Understand the priorities of target populations
- Tailor marketing and outreach to target populations
- Use clear and simple messages

Key considerations

- Prioritizing marketing and outreach efforts
- Timing for marketing and outreach
- Beware not being seen as “another government program”
- Need for balanced risk pool
- Connection with human services

Stakeholder Perspectives on Marketing, Promotion and Outreach

Top outreach and marketing activities:

- Tell the stories of real people
- Leverage existing, trusted community networks
- Use social media to reach young adults
- Work with schools to encourage coverage
- Work with colleges and universities to reach young adults
- Use ethnic media
- Give providers outreach tools
- Tailor outreach strategies for rural communities
- Tailor outreach strategies for small businesses
- Other marketing and outreach strategies to explore
- Special marketing and outreach for SHOP

Strategies to maximize early enrollment

- Maximize use of auto- or pre-enrollment (e.g., LIHP, Family PACT)
- Maximize enrollment in insurance affordability programs by working with entities that serve potentially-eligible individuals (e.g., DMV, schools, Franchise Tax Board)
- Maximize enrollment among individuals who use health services by working with providers

Stakeholder Perspectives on Marketing, Promotion and Outreach

Need strategies to Maximize Retention

- Simplify program rules
- Access to care critical to affirming value of coverage

Effective Messengers and Messages

- Stories from people who benefit from coverage expansion
- Trusted community leaders provide clear and consistent messages

Stakeholder Perspectives on Enrollment Assistance, Navigators, and Health Insurance Agents

Perspectives on entities' roles in providing enrollment assistance

- Balance the need for in-person assistance with cost
- Need all hands on deck
- Different groups start with different core competencies
  - Counties – public program eligibility
  - Consumer groups – public program eligibility and benefits
  - Brokers – private plans and benefit design variation
- Use existing trusted sources
- Diversity of perspectives on roles

Supporting applicants across the continuum of assistance

Self-service (web or mail)	Phone Assistance	In-person Assistance

Key considerations

- Need for assistance will change over time
- Be ready for high need in early years
- Need to clarify scope of assistance (eligibility to enrollment to use of care to retention)

Stakeholder Perspectives on Enrollment Assistance, Navigators and Health Insurance Agents

Methods of payment for enrollment assistance

- No payment
- Flat application payments
- Grants
- Premium-based commissions

Key considerations

- No “one size fits all” payment system
- Consider hybrid payment models (e.g., flat payments and grants)

Requirements and performance standards

- Need for rigorous initial and ongoing training and strong performance standards

Ogilvy Presentation

7. Marketing, Outreach, & Enrollment (Ogilvy)

A Conversation About Building Brands and Considerations for an Outreach Plan to Maximize Health Insurance Coverage for Californians

March 22, 2012

What is a brand?

A brand is a story about an organization's purpose, its people and its products/services – an accumulation of impressions in the mind of audiences; a set of characteristics.

"A well defined **brand** is the most **sustainable** **asset** an organization can have."

— David Ogilvy

What brand are we building?

- Overall Goal
  - As many Californians as possible get and keep health insurance coverage
- Marketing and Communications Goals
  - Communicate the value of and create desire for health insurance
  - Define and promote a new, trusted marketplace for affordable health insurance plans and information
  - Define and promote insurance product offerings, including new Exchange products

A few potential brand attributes for the marketplace

Begin building our brand story and laying the foundation and framework for messaging:

Approachable	Simple, easy
Affordable	Modern
Straightforward	Helpful
Trustworthy	Capable

High quality customer service and information

From Brand to Messaging

- Develop specific messages under the brand umbrella

  Considerations:

  – Messages that resonate with specific insurance customers
    - Cultural perspective – Latinos and many others that make up this diverse target
    - Life stage as a driver of perspective
  – Messages around specific insurance products

From Brand to Messaging

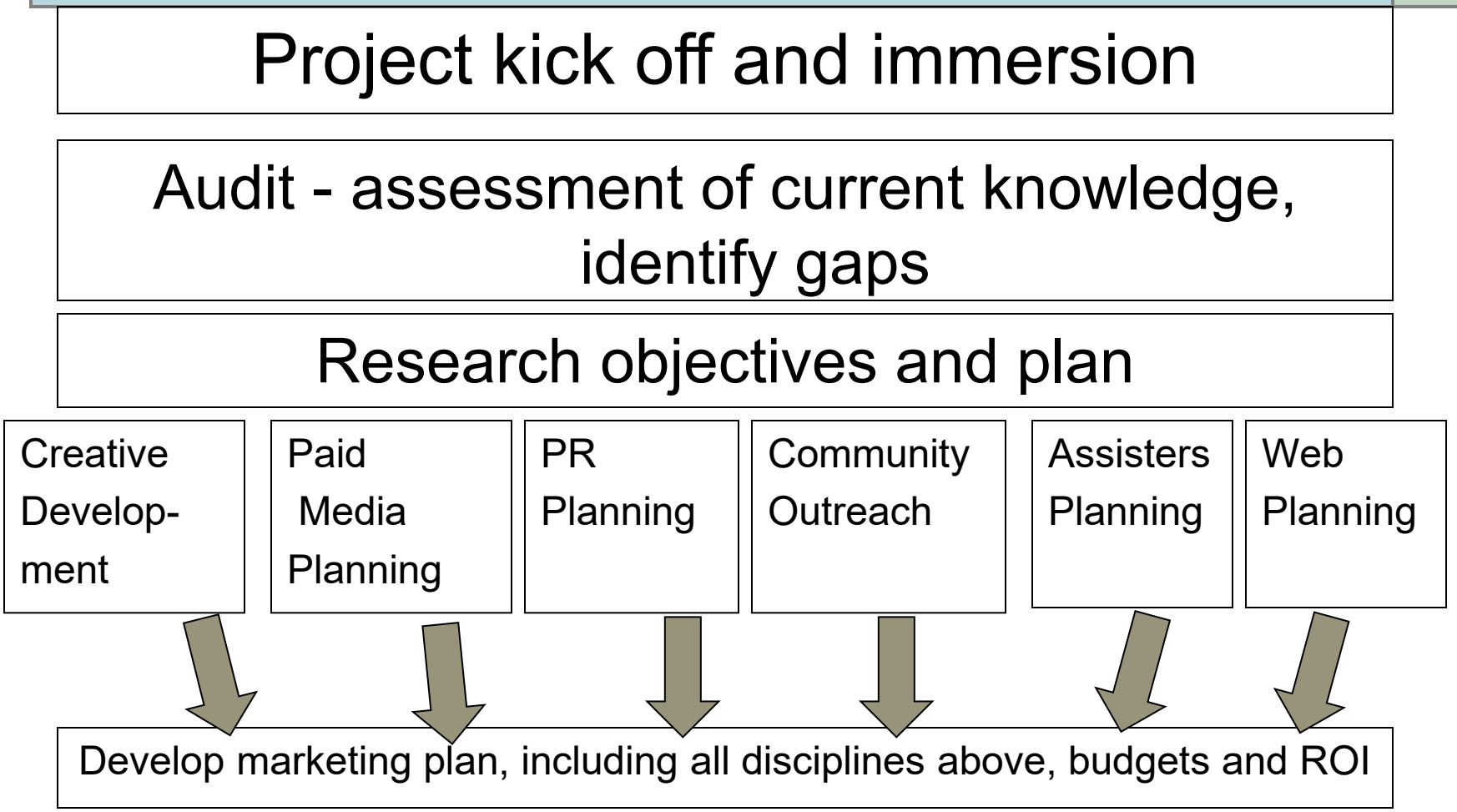
- What higher level benefits might resonate?
  - Economic security
  - Health + wellness + prevention
  - Peace of mind – access to needed care
  - Obligation + responsibility – to loved ones and law abiding

- Relevant messengers are also important - match the message with the messengers

From Branding to Program . . .

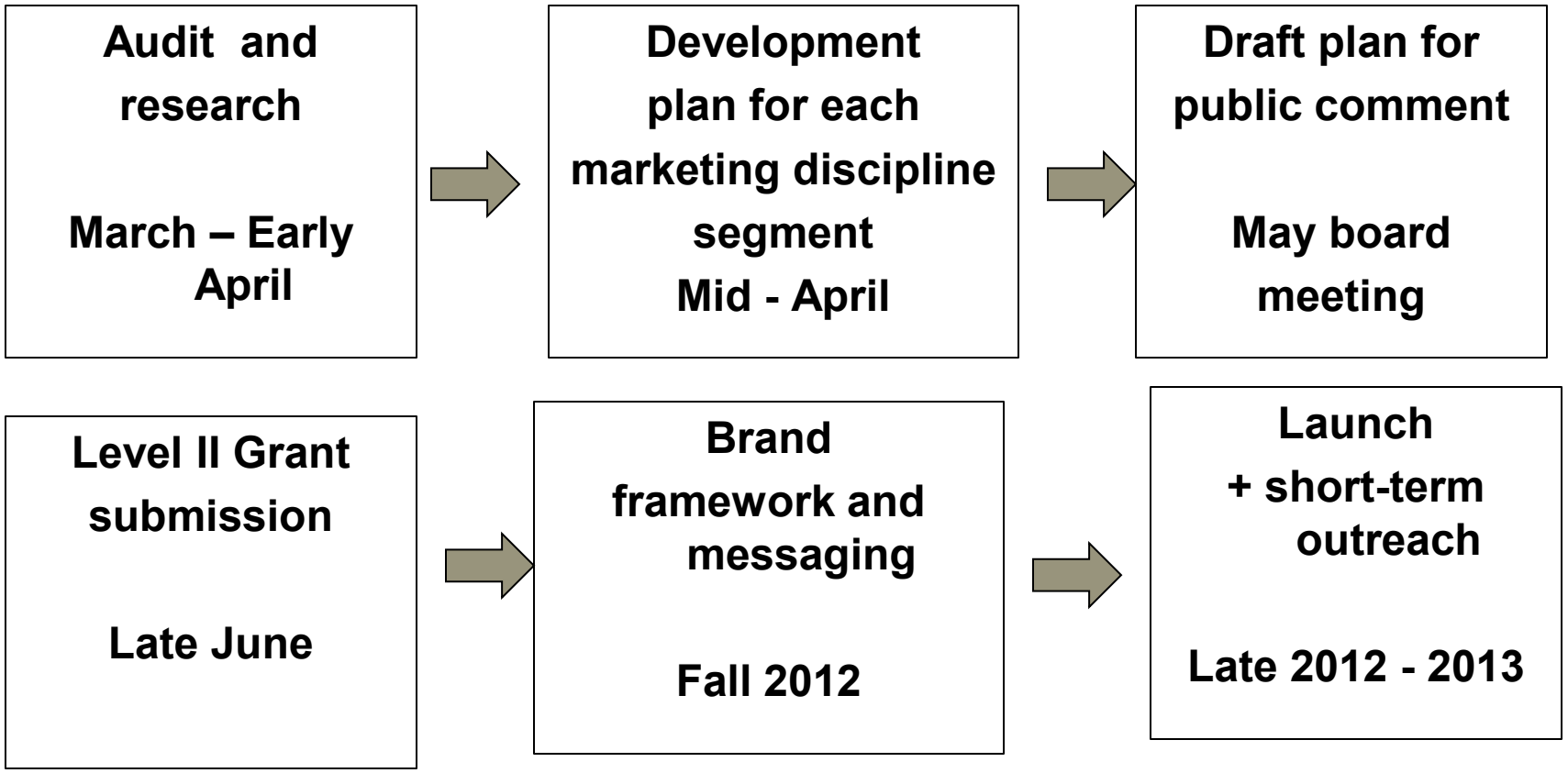
The Planning Process

7. Marketing, Outreach, & Enrollment (Ogilvy)



Timing

7. Marketing, Outreach, & Enrollment (Ogilvy)



We will explore messages by products

- Product usage
  - Medi-Cal
  - Healthy Families
  - Exchange with and without subsidies
  - Employer sponsored

Our initial information audit tells us

The challenge:

- The majority of newly eligible are communities of color
- Many of the newly eligible have English proficiency issues
- Particular terminology issues regarding health care (e.g., co-pays, deductibles, etc.)

Therefore:

- You can't do it alone
- You can't do it in English only
- You have to do it all . . .

Segment messages for different populations

- Culture/Ethnicity
- Age
- Income
- Health Status
- Business target (SHOP)

Initial Latino Audience Insights

- Big differences between Spanish language dominant and English dominant populations
  - Univision/Telemundo/print can reach upwards of 90% of Spanish dominant*
  - Spanish-dominant Hispanics trail bilingual and English-dominant Hispanics in internet and social media use**
- Over 65% of Latinos use some form of social media as a form of communication***
- Messaging: simple, culturally-sensitive, based on community and family
- Importance of influencers – especially local/national television/media personalities

*The Nielsen Company and Stanford University, August 2010
**Pew Research Center, February 2011
***Pew Internet and American Life Project, May 2011

We need partners. . .

- Partnerships with CBOs, health care providers, those in the community are key
- Use of trustworthy influentials and ethnic media personalities are critical
- Involvement of other government entities is a “must” (schools, WIC, CalFresh, Family PAC, DMV, EDD, etc.)

Must be culturally and linguistically sensitive

- In language to certain populations
- Ensure Assisters represent the diversity of California
- Additional research in other languages/cultures
- Simplify and explain health care terminology

Explore the use of all channels

- Traditional Media
- Use of ethnic media
  - Print, radio, television
- Social media
  - Latinos are the biggest purchasers of smart phones in the U.S.*
    - SMS/texting
    - Mobile campaigns
- Community-based engagement

*Univision data, November 2011

Next Steps

7. Marketing, Outreach, & Enrollment (Ogilvy)

- Develop business ambition/objective and brand framework
- Identify short-term research for marketing plan development and long-term needs for program launch
- Develop long-term marketing plan for Level II grant funding

Navigator Strategy

Summary

Developing a navigator strategy is a critical component of the Outreach and Communications plan that will be included in the Exchange's Level II proposal. Navigators will help facilitate eligibility and enrollment.

Issues for consideration

- What should be the role of agents and brokers? How should the Exchange ensure that agents and brokers are not incentivized to steer healthy lives away from the Exchange?
- What should be the role of community based organizations? How can their resources be leveraged to maximize federal funds? How should they be compensated to enhance their efforts and increase enrollment?

Issues for consideration (cont.)

- What strategy should be developed to assure enrollment in minority and "hard to reach" communities?
- How many Navigators will be needed? What level of training for Navigators will necessary?

Current approach

- Richard Heath & Associates (RHA), a subcontractor under the supervision of Ogilivy, will be helping to develop the Navigator plan as part of the overall outreach and communications contract, including programmatic objectives, participation goals, roles for project teams members, timelines and budgets for this effort. This effort will also be informed by the input of stakeholders.

Assisters Discussion Topic

- Availability of Level II grant funds to support community-based outreach and education activities

8. CalHEERS Project Summary

Architecture & Project Baseline Reviews
CalHEERS Concept of Operations
Solicitation Overview
Solicitation HBEx4 Update
CalHEERS Implementation Issues
Artifacts Available on CALT

Architecture and Project Baseline Reviews

8. CalHEERS Project Summary

- On March 5th and 6th, OIS and CCIIO visited California to review the CalHEERS Project. Below is a synopsis of the discussion and outcomes.
- Discussed:
  - Critical dates for successful implementation
  - Plan Management partnership program
  - Coordination, cost allocation and approvals where Exchange impacts Medicaid
  - Solution type options (SaaS, COTS, custom build, etc.)
  - Premium aggregation
  - Reuse considerations
  - Minimum set of functions for “Day-1”
  - Minimum order of operations
  - Real-time services vs. non-real-time
  - Capacity, bandwidth, scalability and volume
  - Critical testing and outcomes – the five key tests
  - Contingency planning

Architecture and Project Baseline Reviews

8. CalHEERS Project Summary

- Outcomes:
  - Requested artifacts to be loaded to CALT 2 weeks prior to planning review
  - Tentatively scheduled Design Review for July/August 2012
  - Requested Cost Allocation methodology via the CalHEERS IAPD

CalHEERS Concept of Operations

The CalHEERS Concept of Operations (ConOps) document:

- Represents the proposed solution for the CalHEERS project
- Describes the key operational concepts of the CalHEERS system
- Describes the functions and characteristics of the computer systems within the overall solution and interactions and interfaces with existing California systems.
- The high-level concepts described are as follows:
  - Scope
  - Concept for the proposed system
  - Operational scenarios for the proposed system
  - Summary of impacts

CalHEERS Concept of Operations

The ConOps also includes architectural diagrams and descriptions around the following:

- CalHEERS Proposed Logical Architecture
- Individual Eligibility and Enrollment
- SHOP Eligibility and Enrollment
- Plan Management
- Financial Management
- CalHEERS Interface Diagram

Solicitation Overview – Core Functionality

8. CalHEERS Project Summary

Functionality to be implemented by 2014:

- Eligibility and enrollment*
- Plan management
- Service Center hardware, software, facilities
- Customer service and education via web portal (English and Spanish)
- Forms, notifications, and IVR in threshold languages
- Eligibility transfer (i.e., pre-enrollment, pre-notification, and pre-population)
- Financial management
- Case data management (two approaches solicited)
- Organizational change management
- Provider directory linkage to plan choice
- Individual premium aggregation
- Small Business Health Options Program (SHOP)

* Includes Modified Adjusted Gross Income (MAGI) Medi-Cal, Children's Health Insurance Program (CHIP), Access for Infants and Mothers (AIM), Advanced Premium Tax Credit (APTC), Cost Sharing Reductions (CSR), if enacted, the Basic Health Program (BHP) based on verified Application data and non-subsidized individual exchange coverage.

Solicitation Overview – Expanded Functionality

Functionality to be priced separately:

- Centralized Provider Directory Database
- Incorporation of other health care services programs (e.g., Breast and Cervical Cancer Treatment Program)
- Incorporation of other non-health care services programs (e.g., CalFresh)
- Incorporation of MEDS functionality (central Medi-Cal eligibility index)
- Translation of web portal to support other threshold languages

Solicitation HBEx4 Update

Proposal Evaluation

- Evaluation began March 6 and is on schedule
- BAFO #1 released on March 19
- BAFO #2 (if needed) released by March 30
- Contract negotiations scheduled for April 10-20
- Tentative Vendor start date of April 17

Solicitation HBEx4 Update

8. CalHEERS Project Summary

Description	Status	Date(s)
Release Solicitation	Complete	01/18/2012
Vendor Conference	Complete	01/27/2012
Cost Schedule Webinar	Complete	02/01/2012
Confidential Concept Presentations	Complete	01/30 - 02/03/2012
Confidential Model Contract Discussions	Complete	02/06 - 02/10/2012
Evaluation Team Training	Complete	02/28/2012
Receive Proposals	Complete	03/05/2012
Proposal Evaluation	In Progress	03/06 – 04/03/2012
Conduct Best and Final Offer #1	Completed	03/19 – 03/22/2012
Score and Compile Results/Conduct BAFO #2 (if necessary)	In Progress	03/22 – 04/03/2012
Oral Presentations and Key Staff Interviews	Not Started	03/28 – 03/30/2012
Vendor Selection Report and Notification to Enter Negotiations	Not Started	04/04 – 04/06/2012
Contract Negotiations and Award (tentative)	Not Started	04/10 – 04/20/2012
Vendor Start (tentative)	Not Started	04/23/2012

CalHEERS Implementation Issues

Issues under consideration

- Contract terms
- Cost allocation
- Project staffing structure
- System capability to support premium aggregation
- System capability to support SHOP program
- Service Center infrastructure
- Alternatives for case data management

Current approach

- Evaluating “bids” from vendors
- Negotiating cost allocation methodology
- Recruiting for Project Director
- Selecting vendor to assist in negotiations

Artifacts Available on CALT

8. CalHEERS Project Summary

ARTIFACT	ARTIFACT DEFINITION	DATE DELIVERED
Concept of Operations (ConOps)	Conceptual functions and stakeholder interactions. The high level concepts covered in the ConOps are: Scope Definition Current System Goals Objectives and Rationale for new or significantly modified system Scenarios Analysis Proposed System Analysis of Proposed System	3/23/2012
Architectural Diagrams within ConOps	Framework to identify the conceptual integration of the underlying business functionality, data, and infrastructure of the intended solution	3/23/2012
Project Management Plan (PMP)	Overall plan for project execution, monitoring, and control. A high level approach overview of the following topics are contained in the PMP:	3/23/2012
Supplemental Plans addressed within the PMP	Assumptions/Constraints/Risks Project Scope Overall Project Management Approach Communication Management Risk Management Configuration Management Change Management Development Approach Quality Management Independent Verification and Management Requirements Management Record Management Security Training Plan	3/23/2012

Artifacts Available on CALT

8. CalHEERS Project Summary

ARTIFACT	ARTIFACT DEFINITION	DATE DELIVERED
Risk Management Plan including Risk Mitigation Strategy (Supplement to PMP)	Identification and potential mitigation of any uncertain events that may impact project objectives	3/23/2012
Risk Register	Identification and potential mitigation of any uncertain events / risks that may impact project objectives	3/23/2012
Gap/Alternatives Analysis	Potential alternatives for project solution design and implementation, and associated conditions when an alternative may be more viable	3/23/2012
MITA State Self Assessment / MITA Roadmap	Self assessment against MITA framework. Conducted at AR and 12 months after MITA 3.0 is released.	3/23/2012
Privacy Impact Assessment	Determines if Personally Identifiable Information (PII) is contained within a system, what kind of PII, what is done with that information, and how that information is protected	3/23/2012
System Security Plan	The plan describes security controls within the system that will protect the confidentiality, integrity, and availability (CIA) of the system and its information	3/23/2012
Information Security Risk Assessment	Identification of risks and possible mitigation associated with information security components and supporting infrastructure	3/23/2012

9. Timeline

Calendar

Calendar

9. Timeline

February	March	April
Information & Discussion	***Information & Discussion***	***Information & Discussion***
QHP and Delivery Reform Landscape: • Plan Designs • Benefit Designs • Provider Contracting • Delivery Reform	Outreach and Assistance Landscape: • Report on outreach input • Eligibility and enrollment estimates • Outreach Models • Assistance Models	1. Basic Health Program Options and Implications 2. Service Center Options 3. SHOP Landscape

May	June	July and Future Months
Information & Discussion	***Decision***	***Decision***
1. Scope/options for outreach and communications 2. Options for Assisters 3. Options for branding/campaign 4. Options for SHOP 5. Options for Qualified Health Plan strategies that impact Level II 6. Rough of Level II Grant (2013-2015 Budgets and plans with completed Draft Components)	1. Outreach and communications plan scope/nature 2. Assisters and broker scope, policies and budget 3. SHOP Policies (as needed for Level II Grant and Alignment with QHP policies) 4. Level II Grant (2013-2015 Budgets and operations plans)	1. QHP and Ben. Design Policies 2. CalHEERS Design and Development 3. SHOP Design and Operational Development 4. Assister/ Navigator Training and Oversight Solicitation 5. Marketing, Outreach and Education Campaign Pre-implementation Activities